FAQs

SUBJECT: KEHP and Participating Employer Compliance with the AFFORDABLE CARE ACT
DATE: 07/10/13

In March of 2010, the Affordable Care Act (ACA) was enacted requiring the implementation of some of the most wide-sweeping reforms to health insurance in the United States ever. While many of those reforms have already been implemented, others will be effective beginning in January 2014.

These FAQs provide guidance and answer questions you may have regarding the implementation of certain ACA provisions and mandates. This FAQ is for informational purposes only. Many ACA mandates and requirements apply specifically to employers. Although this FAQ is intended to provide guidance to employers participating in KEHP, each employer is responsible for ensuring that it is in compliance with all employer ACA mandates.

Denotes a KEHP action item.

Denotes an important update to federal requirements

Employer Play or Pay Mandate

On July 2, 2013, the Department of Treasury announced that employer reporting requirements and Play or Pay penalties would be delayed until 2015. The July 2nd announcement was confirmed in IRS Notice 2013-45 which can be viewed at http://www.irs.gov/pub/irs-drop/n-13-45.pdf/n-13-45.pdf. Despite the new announcement, employers should continue to analyze their workforce, develop a process for counting employees, and make technological and information system changes as necessary to collect and consolidate employee information by the new January 1, 2015 compliance deadline. To that end, this FAQ provides information about the Employer Play or Pay Mandate that might be beneficial to employers as they work toward compliance for 2015.

What is the Employer Play or Pay Mandate?

The ACA amends the Internal Revenue Code (IRC) to add provisions regarding the shared responsibility for employers regarding health coverage. These added provisions are sometimes called the "Employer Shared Responsibility" or the "Employer Play or Pay Mandate."

Under the Employer Play or Pay Mandate, large employers may be subject to penalties if:

a. The employer fails to offer minimum essential coverage for any month to its full-time employees and their dependents, and at least one full-time employee is certified (under the ACA) to receive a premium tax credit or cost-sharing reduction toward the purchase of a qualified health plan through the Marketplace; or
b. The employer offers minimum essential coverage to its full-time employees and their dependents but the coverage is not affordable or does not provide minimum value for any month, and at least one full-time employee is certified (under the ACA) to receive a premium tax credit or cost-sharing reduction toward the purchase of a qualified health plan through the Marketplace.

What is the "Marketplace"?

The ACA addressed several shortcomings that existed in the health insurance market prior to 2010 that prevented individuals from obtaining health insurance coverage. One shortcoming was individuals' inability to find comprehensive affordable health insurance coverage. In response to this problem, the ACA requires each state to establish a Marketplace for purchasing insurance coverage. Individuals will be able to shop for insurance through the Marketplace, and depending upon eligibility, may be able to receive premium tax credits or subsidies to assist in paying for the coverage. Under the law, individuals with a household income between 100 percent and 400 percent of the federal poverty level are eligible for premium tax credits for Marketplace coverage if they do not have access to affordable employer-sponsored coverage that is of at least a minimum value.

Must the employer offer coverage to the employee's dependents and spouse?

The ACA requires large employers to offer minimum essential coverage to its full-time employees *and their dependents.* For the purposes of the Employer Play or Pay Mandate, a dependent refers to an employee's child (including adopted and foster children). An offer of coverage to an employee's spouse is *NOT* required for the purposes of complying with the Employer Play or Pay Mandate.

How much are the penalties for noncompliance?

For large employers that fail to offer health coverage to its employees, the penalty is equal to $2,000 multiplied by the *total* number of full-time employees. The penalty is assessable if at least one full-time employee receives a premium tax credit/subsidy to purchase coverage through the Marketplace.

A large employer that offers health coverage to its employees may also be subject to penalties if any of the employer's full-time employees receive a premium tax credit/subsidy to purchase coverage through the Marketplace. If this occurs, the penalty is equal to $3,000 multiplied by the number of full-time employees receiving a premium tax credit/subsidy to purchase coverage through the Marketplace. An employee is not eligible for a premium tax credit/subsidy if the employer offers minimum essential coverage that is affordable and has a minimum value. See below for more information regarding minimum essential coverage, the affordability test, and the minimum value test.

One twelfth (1/12) of each penalty applies for each month the employer either fails to offer coverage or does not offer affordable coverage that has a minimum value.

Who is responsible for paying the penalties?

The Employer Play or Pay Mandate places the compliance responsibility on the employer, as opposed to an insurance company or a self-insured health plan such as KEHP. Consequently, the employer is responsible for any penalties imposed as a result of noncompliance with the mandate.

When will the IRS assess the penalties against an employer?

Under the ACA, a large employer that does not provide affordable coverage with a minimum value could be subject to penalties beginning January 1, 2014. However, on July 2, 2013, the Department of Treasury announced that two important components of the Employer Play or Pay Mandate would be delayed until 2015. First, after hearing concerns from employers regarding the employer's reporting requirements (see the Reporting Requirements section of this FAQ), the Department of Treasury plans to re-vamp and simplify the reporting process. Until the reporting requirements can be defined further, the Department of Treasury is suspending employer reporting requirements for 2014. The Department of Treasury expects to publish rules implementing the reporting requirements later in the summer of 2013.

The Employer Play or Pay penalties will be assessed based on the information reported by employers. Since the employer reporting requirements are suspended for one year, penalties will not be collected based on an employer's noncompliance with the Play or Pay Mandate in 2014. This allows employers time to test the new reporting systems and make any necessary adaptations to their health benefits.

What does this delay in employer reporting and the imposition of penalties mean for employers?

The delays in implementation announced by the Department of Treasury are intended to allow employers a transition period through 2014. Additional guidance is expected to be released soon from the Department of Treasury regarding the rules that will apply during the 2014 transition period.

Once the Department of Treasury rules have been issued, employers are encouraged to voluntarily implement the information reporting in 2014, in preparation for the full application of the provisions in 2015. Employers should continue to analyze their workforce, develop a process for counting employees, and make technological and information system changes as necessary to collect and consolidate employee information by the new January 1, 2015 compliance deadline. To that end, this FAQ provides information about the Employer Play or Pay Mandate that might be beneficial to employers as they work toward compliance for 2015.

Is there any tolerance for noncompliance or limits on penalty amounts?

Prior to the Department of Treasury's announced delay in implementation of the Employer Play or Pay penalties, the shared responsibility penalty would apply in 2014 only if:

a. The large employer fails to offer health coverage to less than 95% of its full-time employees, and at least one of the full-time employees receives a premium tax credit to help pay for coverage in the Marketplace; or
b. The large employer offers health coverage to at least 95% of its full-time employees, but at least one full-time employee receives a premium tax credit to help pay for coverage in the Marketplace. This may occur because the employer did not offer coverage to that employee or because the coverage the employer offered that employee was either unaffordable or did not provide minimum value.

After 2014, the rule in paragraph (a) above was intended to apply to employers that do not offer health coverage or that offer coverage to less than 95% of their full-time employees and the dependents of those employees.

The penalty for a large employer failing to offer affordable coverage with a minimum value cannot exceed the penalty that would be assessed if the large employer failed to offer coverage at all. Additionally, the number of full-time employees is reduced by 30 for the purposes of calculating the penalty associated with the large employer's failure to offer coverage.

Given the delays in implementation announced by the Department of Treasury, future guidance will likely address how the allowed error tolerance will be applied in 2015 and thereafter.

What constitutes a large employer for the purposes of assessing penalties under the Play or Pay Mandate?

An employer is considered a large employer under the Play or Pay Mandate if the employer employed at least 50 full-time employees (or full-time equivalent employees) on business days during the prior calendar year.

Additionally, the Play or Pay Mandate applies to all large employers including for-profit, not-for-profit, and government entity employers.

Who is a full-time employee or full-time equivalent (FTE)?

A full-time employee is an employee who was employed on average at least 30 hours of service per week (or 130 hours of service per month). Hours of service includes: (1) each hour for which an employee is paid, or entitled to payment, for the performance of duties for the employer; and (2) each hour for which an employee is paid, or entitled to payment by the employer on account of a period of time during which no duties are performed due to vacation, holiday, illness, incapacity, layoff, jury duty, military duty, or leave of absence.

An FTE includes all employees (including seasonal workers) who were not full-time employees for any month in the preceding calendar year. These employees are included in calculating the employer's FTEs for that month by: (1) calculating the aggregate number of hours of service (not more than 120 hours for any employee) for all employees who were not employed on average at least 30 hours of service per week for that month; and (2) dividing the total hours of service in (1) by 120. For example, an employer that employs 40 full-time employees for 30 or more hours per week on average plus 20 half-time employees for 15 hours per week on average will be considered to have 50 full-time employees.

How are substitute teachers counted?

Additional provisions exist in the federal rules for non-traditional workers such as seasonal workers, teachers, and other employees of educational organizations. Educational organizations present a special situation compared to other workplaces because they typically function on the basis of an academic year, which involves various extended periods in which the organization is not in session or is engaged in only limited classroom activities. Many of the employees in educational organizations, while typically employed for at least 30 hours of service per week during the active portions of the academic year, are precluded from working during periods when the organization is entirely or largely closed. The federal rules propose an averaging method for employment break periods that generally would result in an employee who works full-time during the active portions of the academic year being treated as a full-time employee for the purposes of the Play or Pay Mandate.

Many questions have been posed regarding the treatment of substitute teachers. Substitute teachers may work for several different school districts, and it is difficult to anticipate the number of hours a substitute teacher is reasonably expected to work. Federal rules and guidance do not specifically address substitute teachers. In fact, the National School Board Association (NSBA) has written to the Internal Revenue Service (IRS) requesting further guidance on this issue. NSBA's letter may be viewed at http://www.nsba.org/SchoolLaw/Federal-Regulations/IRS-Proposed-Rule-for-Shared-Responsibility-for-Employers-Regarding-Health-Coverage.pdf. Until such guidance is forthcoming, school boards should consider whether the substitute teacher is an "employee," and if so, the school board should analyze the number of hours the substitute teacher worked throughout the past look-back period. See below for information regarding the look-back period.

Why must an employer count its employees?

The Play or Pay penalties are determined on a monthly basis. Because of this, employers need to know which of its full-time employees and their dependents should be offered coverage for any given month. In recognition of the practical difficulties employers may have in predictably identifying which employees are full-time employees to whom coverage must be provided, the federal government permitted an optional look-back measurement at least through the end of 2014. Given the delays in implementation announced by the Department of Treasury, future guidance will likely address whether the optional look-back measurement will be extended through 2015.

What is the look-back measurement option for ongoing employees?

The optional look-back method to determine which ongoing employees are full-time employees in any calendar month is based on a "standard measurement period." The standard measurement period allows the employer to determine whether an employee is an ongoing employee and whether an ongoing employee is a full-time employee. The standard measurement period is set by the employer and is at least 3 but not more than 12 consecutive calendar months. An "ongoing employee" is an employee who is employed on the first day of and for at least one complete standard measurement period.

If an employee works an average of thirty (30) hours of service per week during the standard measurement period, then the employer must treat the employee as a full time employee during a subsequent "stability period." The stability period is the period of time after the end of the standard measurement period during which the employee's status as a full-time employee (or not) remains unchanged, regardless of the number of hours the employee works during the stability period. The stability period must last at least 6 consecutive calendar months and cannot be shorter in duration than the standard measurement period.

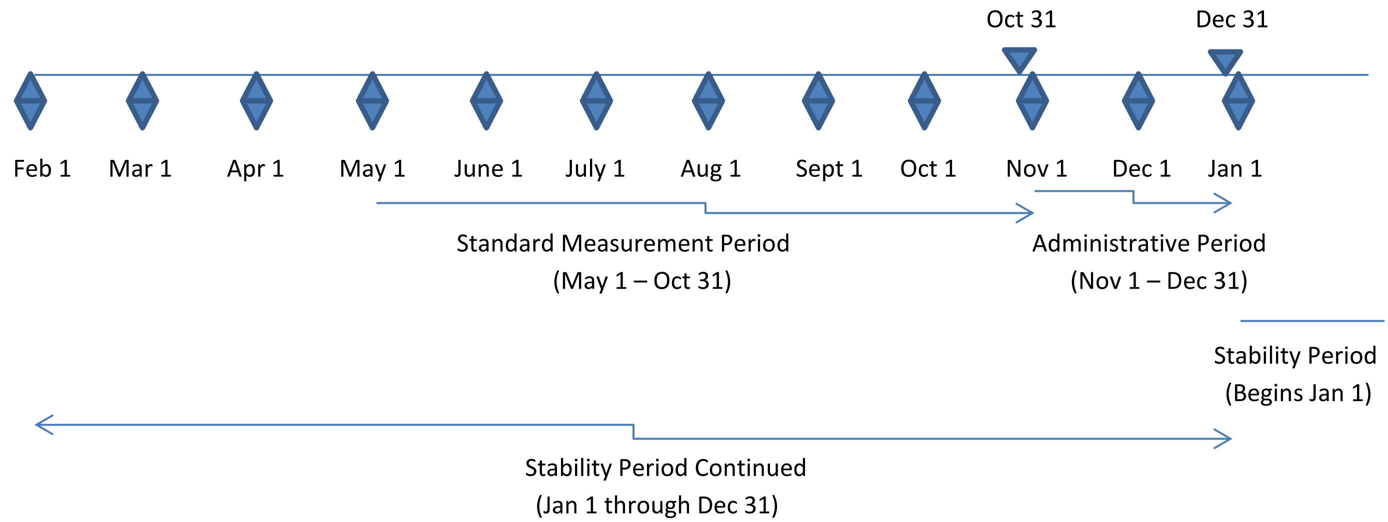
The employer may also use an "administrative period." An administrative period is permitted if an employer needs time between the standard measurement period and the associated stability period to determine which ongoing employees are eligible for coverage. The administrative period following the standard measurement period may last up to 90 days and will overlap any prior stability period.

E.g., standard measurement period = 6 months; administrative period = 2 months; stability period = 12 months. To begin the stability period on January 1, the administrative period must begin on November 1 and end on December 31. The standard measurement period must end on October 31 before the administrative period and begin the preceding May 1. The stability period will last from January 1 through December 31. See Diagram 1 below.

Will the administrative period and the stability period overlap?

Yes. The 2015 stability period will run concurrently with the 2015 administrative period. The Diagram 1 below depicts this overlap and is based on the example periods provided in the previous question. Note that the 2015 stability period begins January 1, 2015, and continues through December 31, 2015. The administrative period begins November 1, 2015, and continues through December 31, 2015.

Diagram 1



How does and employer count new employees?

If a new employee is reasonably expected at his or her start date to work full-time, an employer that offers coverage to the employee at or before the conclusion of the employee's initial 3 calendar months of employment will not be subject to the Play or Pay penalties by reason of its failure to offer coverage to the employee for up to the initial 3 calendar months of employment. Note that the waiting period should not exceed 90 days. See the FAQs regarding the 90-day waiting period.

How does an employer count variable hour and seasonal employees?

The Play or Pay rules provide guidance with respect to variable hour and seasonal employees. The rules specifically provide that employers are permitted to use a reasonable, good faith interpretation of the term seasonal employee but, it is not a reasonable good faith interpretation to treat an employee of an educational organization, who works during the active portions of the academic year, as a seasonal employee.

Is there guidance for other types of employees?

Yes. The Play or Pay rules provide information with respect to the treatment of changes in employment status, new short-term employees, new employees hired into high-turnover positions, and other employee situations. For a better understanding of the rules, employers should review IRS Notice 2011-36, IRS Notice 2011-73, IRS Notice 2012-17, IRS Notice 2012-58 and the proposed rule, "Shared Responsibility for Employers Regarding Health Coverage." These notices and the proposed rule can be viewed at:

IRS Notice 2011-36 - http://www.irs.gov/pub/irs-drop/n-11-36.pdf
IRS Notice 2011-73 - http://www.irs.gov/pub/irs-drop/n-11-73.pdf

IRS Notice 2012-17 - http://www.irs.gov/pub/irs-drop/n-12-17.pdf
IRS Notice 2012-58 - http://www.irs.gov/pub/irs-drop/n-12-58.pdf
Shared Responsibility for Employers Regarding health Coverage – http://www.gpo.gov/fdsys/pkg/FR-2013-01-02/pdf/2012-31269.pdf
http://www.irs.gov/uac/Newsroom/Questions-and-Answers-on-Employer-Shared-Responsibility-Provisions-Under-the-Affordable-Care-Act

Does an employer need to count employees every year?

Yes. Each employer should count and classify employees each year to determine (1) if the employer is a large employer and (2) which employees must be offered coverage.

What should employers do now?

The delays in implementation announced by the Department of Treasury are intended to allow employers a transition period through 2014. Additional guidance is expected to be released soon from the Department of Treasury regarding the rules that will apply during the 2014 transition period.

Despite the delay in reporting and penalties, employers need to review and be familiar with the rules and guidance outlined in IRS Notice 2011-36, IRS Notice 2011-73, IRS Notice 2012-17, IRS Notice 2012-58 and the proposed rule, "Shared Responsibility for Employers Regarding Health Coverage." During the transition period, employers should identify and count full-time employees and FTEs. In doing so, employers should establish a standard measurement period, an administrative period (if any), and a stability period. Employers should use this one-year transition period to prepare for full compliance with the Employer Play or Pay Mandate in 2015 and to avoid future penalties that could be imposed for noncompliance.

What employee protections exist?

New federal regulations provide that no employer may discharge or otherwise retaliate against an employee with respect to the employee's compensation, terms, conditions, or privileges of employment because the employee received a premium tax credit or cost-sharing subsidy under the ACA when purchasing coverage through the Marketplace. The ACA also prohibits retaliation against an employee who:

a. Provided, caused to be provided, or is about to provide or cause to be provided to the employer, the federal government, or the attorney general of a state, information relating to any violation of, or any act or omission the employee reasonably believes to be a violation of the ACA;
b. Testified, assisted, or participated (or is about to take any of these actions) in a proceeding concerning such violation; or
c. Objected to or refused to participate in an activity that the employee reasonably believed to be in violation of the ACA.

"Retaliation" includes intimidating, threatening, restraining, coercing, blacklisting, reducing pay or hours, or disciplining an employee.

Employers should be careful when making business decisions that are intended to avoid provisions of the ACA and that can be viewed as retaliation against employees. The procedures for filing and handling a retaliation complaint can be found at 29 CFR Part 1984. For more information on the ACA whistleblower protections, please go to:

http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=FEDERAL_REGISTER&p_id=23585
http://www.osha.gov/Publications/whistleblower/OSHAFS-3641.pdf?

What kind of coverage must large employers offer to their full-time employees?

Large employers that intend to offer coverage to their full-time employees in order to comply with the Play or Pay Mandate must provide affordable minimum essential coverage that has a minimum value.

What is "minimum essential coverage"?

Minimum essential coverage means any of the following:

a. Government-sponsored programs such as Medicare, Medicaid, and the CHIP program;
b. With respect to an employee, employer-sponsored plans;
c. Plans in the individual market;
d. Grandfathered health plans;
e. Other health benefits coverage that may be recognized by the Secretary of HHS, such as the state health benefits risk pool.

Minimum essential coverage includes insurance coverage under an eligible employer-sponsored plan including coverage offered by an employer to an employee that is a governmental plan. Employers participating in KEHP will provide minimum essential coverage in 2014 as KEHP is an employer-sponsored governmental plan.

What is "affordable" minimum essential coverage?

Minimum essential coverage is affordable if the employee's required contribution for self-only coverage does not exceed 9.5% of the employee's household income for the taxable year. IRS Notice 2012-58 provides a safe harbor that allows employers to use an employee's Form W-2 (Box 1) wages for affordability determinations. KEHP will offer plan(s) with employee contribution amounts that will result in affordable minimum essential coverage options in 2014. If an employer group participating in KEHP offers employer or employee contributions different than those established by KEHP, the employer will need to conduct its own analysis to determine if the minimum essential coverage is affordable.

What is minimum essential coverage with minimum value?

Minimum essential coverage meets the minimum value test if the plan's share of the total allowed costs of benefits provided under the plan is equal to or more than 60% of those costs. KEHP will provide minimum essential coverage with minimum value in 2014.

What responsibility does the Employer have to ensure the coverage options through KEHP are affordable and have a minimum value?

KEHP will ensure that plan(s) available for participating groups will meet the affordability and the minimum value tests. It is likely that not all plans offered through KEHP will meet the test for every employee, but at least one plan that meets both tests will be available for every employee. No employer action is required to ensure the coverage offered through KEHP meets the affordability and minimum value tests, provided the employer does not make any changes to the employer or employee contributions established by KEHP. If an employer group participating in KEHP offers employer or employee contributions different than those established by KEHP, the employer will need to conduct its own analysis to determine if the minimum essential coverage is affordable.

Marketplace Notice Requirements

What is the Marketplace Notice requirement?

On May 8, 2013, The US Department of Labor (DOL) issued Technical Release No. 2013-02 providing guidance on the Notice to Employees of Coverage Options under the Fair Labor Standards Act (FLSA) §18B. The ACA added §18B of the FLSA and required an "applicable employer" to provide each employee notice regarding their insurance coverage options. The notice was originally required to be given to each current employee not later than March 1, 2013. In January 2013, the DOL delayed implementation of the notice requirement in order to coordinate the notice with the U.S. Department of Health and Human

Service's (HHS's) educational efforts and IRS guidance on minimum value. In conjunction with the guidance, the DOL issued a model Notice that may be used by employers who offer a health plan to some or all employees.

You may review the Technical Release and the model Notice at http://www.dol.gov/ebsa/newsroom/tr13-02.html.

What are the required contents of the Notice?

The notice to inform employees of coverage options must:

a. Inform the employee of the existence of the Marketplace including a description of the services provided by the Marketplace, and the manner in which the employee may contact the Marketplace to request assistance;
b. Advise that the employee may be eligible for a premium tax credit under §36B of the IRC if the employer plan's share of the total allowed costs of benefits provided under the plan is less than 60% of such costs and the employee purchases a qualified health plan through the Marketplace; and
c. Advise that the employee may lose the employer contribution (if any) to any health benefits plan offered by the employer and that all or a portion of such contribution may be excludable from income for Federal income tax purposes if the employee purchases a qualified health plan through the Marketplace.

What is the purpose of the Notice?

The ACA established an individual mandate requiring applicable individuals to procure insurance for themselves and for their dependents. The Notice advises employed individuals that health insurance coverage may be obtained through the Marketplace. The Notice also advises that an employee who purchases insurance through the Marketplace, rather than purchasing insurance offered by the employer, may lose employer premium contributions. Lastly, the Notice advises employees that if the employer's coverage meets certain standards (affordable with a minimum value), the employee will not be eligible for premium tax credits through the Marketplace.

The model Notice includes Part B which requests specific information about the employer and employee. Does this section need to be completed for each employee before delivering the required Notice?

No. The ACA lists the required contents for the Notice which are outlined above. There is no requirement in the ACA that the Notice contain specific information about the employer or the employee. Therefore, including Part B with the Notice is *optional* for the employer.

Why is Part B included with the model Notice if it is not required?

The application for purchasing insurance through the Marketplace requests information found in Part B of the model Notice. An employee seeking coverage through the Marketplace may seek answers to the questions in Part B from the employer. Each employer should be able to provide this information to its employees upon request. For this reason, KEHP will provide to the employers answers to Part B that would apply to all participating employers. Upon request by the employee, each employer will need to complete Part B with employer-specific information, including any employer-specific eligibility requirements, and return it to the employee. Part B does not have to be included with Part A when delivering the Notice to employees.

Must employers use the model Notice?

No. Technical Release No. 2013-02 regarding the model Notice specifically provides that an employer may use the model Notice or a modified version, provided the Notice includes the required contents.

Who is required to send the Notice?

All employers, regardless of the number of employees, to which the FLSA applies are required to send the notice. The FLSA applies to federal, state, and local government agencies. Ensuring that each employee receives the Notice is an employer responsibility and not the responsibility of KEHP.

Who must receive the Notice?

The employer must deliver the Notice to all employees, regardless of part-time or full-time status and regardless of whether the employee is covered under the employer's health plan. Employers are NOT required to provide a separate notice to dependents or other individuals who are or may become eligible for coverage under the plan but who are not employees.

When must the Notice be given?

Regarding current employees, the Notice must be given not later than October 1, 2013. KEHP intends to include a copy of the Notice with open enrollment materials which will go to current employees; however, employers are also encouraged to send either the KEHP sample Notice or the employer's own modified version of the Notice to current employees. Employers that choose to draft their own version of the Notice must ensure their Notice includes the required contents as outlined above.

With respect to new employees, the Notice must be given at the time of hiring beginning October 1, 2013. Employers will be responsible for delivering the Notice to new employees hired after October 1, 2013.

How must the Notice be delivered to the employee?

The Notice must be provided in writing and in a manner calculated to be understood by the average employee. It may be provided by first-class mail. The Notice may also be provided electronically if (1) the employee has the ability to effectively access documents furnished in electronic form at any location where the employee is reasonably expected to perform his or her duties as an employee and (2) access to the employer's electronic information system is an integral part of the employee's duties.

Will KEHP draft a Notice for employer use?

Yes. KEHP produced a sample Notice containing KEHP-specific coverage information in Part B. The sample Notice is included with this FAQ. Employers may choose to use KEHP's sample Notice or they may draft their own modified Notice. The KEHP sample Notice is the DOL's model Notice with contact information added.

Part A of the sample Notice will be included with the 2014 open enrollment materials.

Part B of the sample Notice will not be included with open enrollment materials but will be provided to employers to assist in responding to employees who seek coverage through the Marketplace.

Employers should take action to ensure that each employee (both current employees and new employees after 10/1/13) ultimately receives the Notice in accordance with the permitted delivery requirements. See above for information regarding the Notice delivery requirements.

The Reinsurance and PCORI Fees

What is the Transitional Reinsurance Fee?

In an effort to stabilize insurance premiums on high-risk individual health insurance policyholders entering the insurance market beginning in 2014, the ACA includes a new mandated Transitional Reinsurance Fee imposed upon a health insurance issuer or a self-insured group health plan. Funds from this new fee will be used to make payments to health insurance issuers (insurance companies) to offset high costs associated with providing insurance to new high-risk/high-cost individuals.

Who will pay the Transitional Reinsurance Fee for plan year 2014?

The ACE requires self-insured group health plans to pay the Transitional Reinsurance Fee. Since KEHP is a self-insured group health plan, KEHP will pay the Transitional Reinsurance Fee to the federal government for plan year 2014.

How long will the Transitional Reinsurance Fee be applicable?

The Transitional Reinsurance Fee will be applicable for plan years 2014 through 2016.

How will the Transitional Reinsurance Fee be calculated?

The fee will be calculated by multiplying the number of covered lives under the KEHP plans by the contribution rate established by the federal government for the applicable benefit year. For 2014, the contribution rate is $63 per covered life (or

$5.25 per member per month). Estimated fees for 2015 are $37.80 per covered life and for 2016, the fees are estimated to be $25.20 per covered life.

When is the Transitional Reinsurance Fee due?

KEHP must notify HHS of the covered life count by November 15th of each year for the first 9 months of that year. HHS will determine the amount of the fee and will bill the entity by December 15. Payment will be due within 30 days.

What is the PCORI fee?

The ACA established a private, nonprofit corporation called the Patient-Centered Outcomes Research Institute (PCORI). PCORI is responsible for conducting federally-sponsored "comparative clinical effectiveness research." Comparative clinical effectiveness research means research into the clinical effectiveness, risks, and benefits of medical treatments, services, drugs, and medical services. The ACA requires plan sponsors of self-insured plans, such as KEHP, to pay fees to finance PCORI's research initiatives.

Who will pay the PCORI fees in 2013?

With respect to self-insured health plans, the ACA specifies that the PCORI fees are required to be paid by the plan sponsor. In the case of a plan established or maintained by 2 or more employers or jointly by 1 or more employers and 1 or more employee organizations, the plan sponsor is the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan. With respect to PCORI fees, the Commonwealth of Kentucky is the plan sponsor and will pay these fees in 2013.

How long will the PCORI fee be applicable?

The PCORI fee is applicable to each policy year ending after September 30, 2012. The fee no longer applies for policy years ending after September 20, 2019.

How will the PCORI fee be calculated?

For each plan year ending after September 30, 2012, the ACA imposes a fee equal to $2 ($1 in the case of plan years ending during fiscal year 2013) multiplied by the average number of lives covered under the plan. So, for plan years ending before October 1, 2013, the fee is $1 per covered life. For plan years ending on or after October 1, 2013, and before October 1, 2014, the fee increases to $2 per covered life. For plan years ending on or after October 1, 2014, the fee amount will be $2 per covered life but is subject to adjustment based on health expenditure inflation.

Federal rules explicitly state that continuation coverage, i.e. COBRA, must be taken into account in determining the PCORI fee.

When is the PCORI fee due?

KEHP must report and pay the PCORI fee for a plan year no later than July 31 of the year following the last day of the plan year. The first payment will be due on July 31, 2013.

Employer Reporting Requirements

How will an employer know that it owes a Play or Pay penalty?

If found to not be in compliance with the Employer Play or Pay Mandate, the IRS will contact employers directly to inform them of their potential liability and provide the employer an opportunity to respond before a penalty is assessed. The contact by the IRS for a given calendar year will not occur until after the employees' individual tax returns are due for that year and after the due date for large employers to file the *information returns* identifying their full-time employees and describing the coverage that was offered.

On July 2, 2013, the Department of Treasury announced that two important components of the Employer Play or Pay Mandate would be delayed until 2015. First, after hearing concerns from employers regarding the employer's reporting requirements, the Department of Treasury plans to re-vamp and simplify the reporting process. Until the reporting requirements can be defined further, the Department of Treasury is suspending employer reporting requirements for 2014. The Department of Treasury expects to publish rules implementing the reporting requirements later in the summer of 2013.

The Employer Play or Pay penalties will be assessed based on the information reported by employers. Since the employer reporting requirements are suspended for one year, penalties will not be collected based on an employer's noncompliance with the Play or Pay Mandate in 2014. This allows employers time to test the new reporting systems and make any necessary adaptations to their health benefits.

Based on the delays announced by the Department of Treasury, it is likely that employers will not be required to report information returns until January of 2016. However, specific guidance and the reporting rules will be forthcoming from the Department of Treasury.

What information must large employers file on their information returns?

The ACA amends the IRC to require large employers subject to the Play or Pay Mandate to make a "return." The Secretary of the Treasury may prescribe additional content requirements, but the return must, at a minimum, contain the following:

a. Name, date, and employer identification number of the large employer;
b. A certification as to whether the employer offers to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan;
c. If the employer certifies that the employer did offer to its full-time employees (and their dependents) the opportunity to so enroll, the return must include:
    1. the length of any waiting period (as defined in section 2701(b)(4) of the Public Health Service Act) with respect to such coverage;
    2. the months during the calendar year for which coverage under the plan was available;
    3. the monthly premium for the lowest cost option in each of the enrollment categories under the plan; and
    4. the applicable large employer's share of the total allowed costs of benefits provided under the plan;
d. The number of full-time employees for each month during the calendar year;
e. The name, address, and TIN of each full-time employee during the calendar year and the months (if any) during which such employee (and any dependents) were covered under any such health benefits plans; and
f. Such other information as the Secretary of the Treasury may require.

Further guidance and rules regarding the employer reporting requirements will be forthcoming from the Department of Treasury.

What information must employers furnish to each full-time employee?

In addition to the information required in the employer's return, every applicable large employer is required to furnish to each full-time employee whose name is on the employer's return, a written statement showing:

a. The large employer's name and address;
b. The large employer's contact information, including a phone number; and
c. The information relating to coverage provided to that employee (and dependents) that is required to be reported on the employer's return.

Further guidance and rules regarding the employer reporting requirements will be forthcoming from the Department of Treasury.

How can I get more information regarding the employer's reporting requirements?

IRS Notices 2012-32 and 2012-33 suggest that proposed regulations are expected to include guidance intended to minimize administrative burden and duplicative reporting. The notices may be viewed at http://www.irs.gov/pub/irs-drop/n-12-33.pdf and http://www.irs.gov/pub/irs-drop/n-12-32.pdf. Further, on July 2, 2013, the Department of Treasury announced that employer reporting requirements would be delayed until 2015. The July 2nd announcement was confirmed in IRS Notice 2013-45 which can be viewed at http://www.irs.gov/pub/irs-drop/n-13-45.pdf/n-13-45.pdf. After hearing concerns from employers regarding the employer's reporting requirements, the Department of Treasury plans to re-vamp and simplify the reporting process. Until the reporting requirements can be defined further, the Department of Treasury is suspending employer reporting requirements for 2014. The Department of Treasury expects to publish rules implementing the reporting requirements later in the summer of 2013.

Who is responsible for complying with the employer reporting requirements?

The reporting requirements are the responsibility of the employer, not KEHP. Employers should review the information required to be reported and consider any actions necessary to ensure the required information can be gathered and reported in accordance with federal reporting requirements.

When will employers be required to submit the required return?

The ACA requires large employers to submit an information return with employee data on or after January 1, 2014. The ACA would have required large employers to file the first information return in 2015. On July 2, 2013, the Department of Treasury announced that employer reporting requirements would be delayed until 2015. Given this delay, it is likely that the first information return will not be required until January 2016; however, additional guidance and rules will be forthcoming from the Department of Treasury.

What are the employer's responsibilities regarding reporting the cost of group health insurance coverage?

The ACA amends the IRC to require employers to provide a written statement to each employee regarding the aggregate cost of applicable employer-sponsored coverage. This reporting requirement applied to taxable years beginning after December 31, 2010. In Notice 2010-69, the IRS granted interim relief to employers by delaying the mandatory reporting until January 2013. The IRS provided other transitional relief to certain categories of employers. In general, however, employers should have included the cost of group health insurance coverage on the employees' 2012 Forms W-2 delivered to employees in January 2013.

Interim IRS guidance on informational reporting to employees of the cost of their employer-sponsored group health plan coverage answers questions regarding the information and methods of reporting the cost of the coverage. The guidance can be viewed at http://www.irs.gov/irb/2011-16_IRB/ar08.html.

Employers should already be reporting the cost of their employer-sponsored group health plan coverage on their employees' W-2 forms. If you are an employer that is not currently reporting this information, you should review the guidance as soon as possible.

Note: This FAQ may not address all employer reporting requirements imposed by the ACA.

Grandfathered vs. Non-Grandfathered

What does it mean to be a "grandfathered plan"?

Prior to the enactment of the ACA, President Obama made clear to Americans that "if you like your health plan, you can keep it." The President's "keep-your-plan promise" was effectuated through the ACA's exemption of most health plans that existed on March 23, 2010 – the day the ACA was enacted. Those exempted plans are referred to as "grandfathered" plans.

What are the advantages and disadvantages of being a grandfathered plan?

The concept of grandfathering health plans allowed persons covered under an insurance policy to keep the coverage they had prior to the enactment of the ACA. Even though many plans were grandfathered, certain consumer protections of the ACA that took effect on September 23, 2010, applied to all plans, even grandfathered plans. Those consumer protections include the prohibition against lifetime dollar limits, the prohibition against rescinding policies, and the requirement to offer dependent coverage to age 26.

Even though certain consumer protections applied to grandfathered plans, others did not. For instance, the ACA required non-grandfathered plans to provide preventive care coverage at 100% without cost-sharing (co-payments/deductibles/co-insurance). Grandfathered plans are not required to provide this coverage.

How do plans lose grandfathered status?

Plans will lose grandfathered status if, after 2010, certain changes are made to the plan design, co-insurance charges, co-payments, deductibles, or employee and employer contributions.

Is the Kentucky Employees' Health Plan a grandfathered plan?

Since the enactment of the ACA, KEHP has been a grandfathered plan.

Will KEHP continue to be a grandfathered plan?

Though no final determinations have been made, KEHP anticipates changes in plan designs that will result in KEHP losing grandfathered status in 2014.

How will losing grandfathered status affect my insurance coverage?

The primary change to KEHP plans after losing grandfathered status will be the inclusion of preventive services with no cost-sharing requirement. The no cost-sharing requirement applies only when the preventive services are delivered by a network provider. No cost-sharing means that preventive services are provided at no cost to the member; there can be no deductibles, co-insurance, or co-payments required when obtaining preventive services under the plan. See the FAQs on Consumer Protections for more information on preventive services.

90-Day Waiting Period

What is the 90-day waiting period?

The ACA provides that a group health plan shall not apply any waiting period for coverage that exceeds 90 days. A waiting period is the period that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of a group health plan can become effective.

What does it mean when an employee is "otherwise eligible to enroll"?

An employee is "otherwise eligible to enroll" when the employee/dependent has met all substantive eligibility conditions such as job-related licensure requirements or being in an eligible job classification. Eligibility conditions based solely on lapse of time are permissible but cannot be for more than 90 days. In general, conditions for eligibility under the terms of a group health plan are permissible unless the condition is designed to avoid compliance with the 90-day waiting period limitation.

Can an employer establish an eligibility condition based on an employee regularly having a specified number of hours?

Yes. If an employer conditions eligibility on an employee regularly having a specified number of hours of service per period, and it cannot be determined that a newly-hired employee is reasonably expected to regularly work that number of hours per period, the plan may take a reasonable period of time, not to exceed 12 months and beginning on any date between the employee's start day and the first day of the first calendar month following the employee's start date, to determine whether the employee meets the plans eligibility condition. Except in cases in which a waiting period that exceeds 90 days is imposed in addition to a measurement period, the time period for determining whether such an employee meets the plan's eligibility condition will not be considered to be designed to avoid compliance with the 90-day waiting period limitation. In this case, coverage must be made effective no later than 13 months from the employee's start date (or the first day of the next calendar month if the employee's start date is not the first day of a calendar month).

Does the 90-day waiting period limitation require coverage for particular employees?

No. The 90-day waiting period limitation does not require the plan sponsor to offer coverage to any particular employee or class of employees. Instead, the 90-day waiting period limitation prohibits requiring otherwise eligible participants and beneficiaries to wait more than 90 days before coverage is effective.

How is the 90-day waiting period counted?

The waiting period may not extend beyond 90 days and all calendar days are counted beginning on the enrollment date, including weekends and holidays. For example, if a plan imposes a 90-day waiting period and the 91st day is a weekend or holiday, the plan may choose to permit coverage to be effective earlier than the 91st day. In no event may the plan make the effective date of coverage later than the 91st day.

Does KEHP plan to establish a uniform waiting period for all participating groups?

Yes. To ensure compliance with the ACA, KEHP has established a uniform waiting period for all participating employers. Beginning January 1, 2014, the waiting period for all employers participating in KEHP will be the 1st day of the 2nd month after the employee/dependent is otherwise eligible to enroll under the terms of the group health plan. An employer that chooses to establish a waiting period different than KEHP's uniform waiting period is responsible for ensuring compliance with the 90-day waiting period limitation.

Is there a phase-in period for implementing the 90-day waiting period limitation?

No. Compliance with the 90-day waiting period must begin January 1, 2014. For employees who are in a waiting period for coverage as of January 1, 2014, the 90-day limitation is applied to the entire waiting period, including any amounts of time that passed prior to January 1, 2014.

What actions must employers with waiting periods longer than 90 days need to take?

Employers with waiting periods different than the uniform waiting period established by KEHP may need to take action to ensure that publications, materials, and processes reflect the uniform waiting period effective January 1, 2014. Please contact the Department of Employee Insurance with any questions.

If an employee is in the middle of a waiting period on January 1, 2014, the employee's waiting period may need to be shortened if it would exceed 90 days.

Consumer Protections Recap

What new consumer protections will be included in the KEHP 2014 plan options?

The ACA established several consumer protections. Many of these protections exist in the current and prior KEHP plans such as the ability to seek emergency care outside your plan's network. Other consumer protections do not apply to grandfathered plans, such as preventive services without cost-sharing. Lastly, the ACA established consumer protections that apply to grandfathered and non-grandfathered plans, such as the prohibition against rescinding an individual's policy except in the event of fraud or a material misrepresentation. This FAQ addresses some of the major consumer protections that will impact the KEHP plans in 2014.

The ACA prohibits discrimination based on a health factor or pre-existing condition. How will this affect the KEHP plans in 2014?

The ACA prohibits group health plans from imposing pre-existing condition exclusions. This ensures that all persons can comply with the individual health insurance coverage mandate. A person that applies for and pays the applicable premium can obtain health insurance coverage.

A group health plan (or an employer sponsor) may not establish any rule for eligibility for any individual to enroll for benefits under the terms of the plan that discriminates based on any health factor related to that individual or a dependent of that individual. Benefits must be uniformly available to all similarly situated individuals and cannot be directed at individual participants or beneficiaries. Further, special rules govern wellness programs ensuring that persons are not discriminated against based on a health factor.

In 2014, KEHP plans will comply with the ACA anti-discrimination provisions. Employers must ensure that no employer eligibility rules discriminate against an employee based on a health factor or a pre-existing condition.

The ACA prohibits lifetime dollar limits. How will this affect the KEHP plans in 2014?

Prior to the ACA, many health plans imposed lifetime dollar limits. Lifetime dollar limits are dollar limits on what the plan would spend for covered benefits during the entire time an insured was enrolled in that plan. The prohibition against lifetime limits applied to all health plans, including grandfathered plans, beginning September 23, 2010. As a result, the KEHP plans currently do not impose lifetime limits on benefits and will not impose such limits in 2014.

The ACA prohibits annual dollar limits. How will this affect the KEHP plans in 2014?

Beginning January 1, 2014, the ACA bans annual dollar limits on essential health benefits in grandfathered plans. Annual dollar limits are maximum benefits a health plan will pay in one year while an employee/dependent is covered under the plan. Essential health benefits are items and services within 10 categories of services identified in the ACA. The ten categories of services are:

a. Ambulatory patient services;
b. Emergency services;
c. Hospitalization;
d. Maternity and newborn care;
e. Mental health and substance use disorder services, including behavioral health treatment;
f. Prescription drugs;
g. Rehabilitative and habilitative services and devices;
h. Laboratory services;
i. Preventive and wellness services and chronic disease management; and
j. Pediatric services, including oral and vision care.

If KEHP loses grandfathered status in 2014, KEHP will make necessary plan design changes to eliminate any annual dollar limits on essential health benefits included in the plans. It should be noted that the prohibition against annual dollar limits does not prevent a plan from imposing visit limits.

The ACA requires coverage of preventive Services with no cost sharing. How will this affect the KEHP plans in 2014?

The ACA requires non-grandfathered plans to cover preventive services without imposing a copayment, deductible, or other cost-sharing requirement on the plan member. Should KEHP lose grandfathered status for plan year 2014, all KEHP plans will include coverage for preventive services without cost-sharing.

Preventive services include routine vaccinations; screening for certain diseases or health problems such as diabetes, cancer, and high blood pressure; contraceptives; well-woman visits; well-baby and well-child visits; oral health risk assessments for children; and many other preventive health care services. With respect to womens' health, preventive care and screening provided for in the comprehensive guidelines supported by the Health Resources and Services Administration or HRSA are covered. The HRSA guidelines include coverage for well-woman visits, screening for gestational diabetes, contraceptives, breast feeding supplies, and other services. A full listing of preventive services that must be covered can be viewed at http://www.healthcare.gov/news/factsheets/2010/07/preventive-services-list.html#CoveredPreventiveServicesforAdults.

It is important to note that the rules governing coverage of preventive services allow plans to use reasonable medical management techniques to control costs and promote efficient delivery of care. For example, plans will retain the flexibility to require cost-sharing for branded drugs if a generic version is available and just as effective and safe. Also, aspirin and other over-the-counter recommended items and services will be covered without cost-sharing *only* when prescribed by a health care provider.

Is KEHP required to cover a member's child up to age 26?

Yes. A group health plan offering health insurance coverage that provides dependent coverage of children is required to make such coverage available for an adult child until the child turns 26 years of age. This coverage is available even if the adult child is married, not living with or financially dependent on the child's parents, attending school, or eligible to enroll in the child's own employer's plan. Employers should ensure that their documents, publications, and materials reflect this change in dependent eligibility.

The ACA requires coverage of services related to a clinical trial. How will this affect the KEHP plans in 2014?

A non-grandfathered group health plan providing coverage to a qualified individual may not:

a. Deny the individual participation in an approved clinical trial with respect to the treatment of cancer or another life-threatening disease or condition;
b. Deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; or
c. Discriminate against the individual based on participation in the trial. The plan can require use of an in-network provider if the provider will accept the individual as a participant.

A "qualified individual" is generally a participant or beneficiary who is eligible to participate in an approved clinical trial according to the trial protocol with respect to the treatment of cancer or another life-threatening disease or condition; and either: (1) the referring health care professional is a participating provider and has concluded that the individual's participation in such trial would be appropriate; or (2) the participant or beneficiary provides medical and scientific information establishing that the individual's participation in such trial would be appropriate.

Provided KEHP loses grandfathered status in 2014, all KEHP plans must comply with the coverage requirements regarding clinical trials.

Individual Health Insurance Coverage Mandate

What is the Individual Mandate?

The ACA amends the IRC to provide that an "applicable individual" must, for each month beginning after 2013, ensure that the individual and any dependent of the individual who is an applicable individual, is covered under minimum essential coverage for such month. A taxpayer who is an applicable individual and who fails to obtain minimum essential coverage will be subject to a penalty. In other words, individuals must purchase health insurance or be subject to an additional tax imposed by the federal government.

Who is an Applicable Individual?

An "applicable individual" is, with respect to any given month, an individual <u>except</u>:

a. An Individual to whom a religious exemption applies in accordance with 26 USC 5000A(d)(2);
b. An individual who is not a citizen, national, or alien lawfully present in the United States; and
c. An incarcerated individual.

What is "minimum essential coverage"?

Minimum essential coverage means any of the following:

f. Government-sponsored programs such as Medicare, Medicaid, and the CHIP program;
g. With respect to an employee, employer-sponsored plans;
h. Plans in the individual market;
i. Grandfathered health plans;
j. Other health benefits coverage that may be recognized by the Secretary of HHS, such as the state health benefits risk pool.

What are the penalties imposed for failing to obtain minimum essential coverage?

The penalties established by the ACA for an individual who fails to obtain minimum essential coverage are:

a. For 2014, $95 per uninsured person (up to 3 people) or 1% of household income over the tax filing threshold;
b. For 2015, $325 per uninsured person (up to 3 people) or 2% of household income over the tax filing threshold;
c. For 2016 and beyond, $695 per uninsured person (up to 3 people) or 2.5% of the household income over the tax filing threshold; and
d. For 2017 and beyond, the penalty will be the same as 2016 but adjusted annually for cost-of-living increases.

In addition to the 3-person penalty limit, a household's penalty is capped at the cost of a bronze-level health insurance plan purchased through the Marketplace.

The penalties listed above are yearly penalties and will be prorated based on the number of months that an individual fails to obtain minimum essential coverage. For individuals under 18 years old, the applicable per-person penalty is one-half of the amounts listed above.

How can individuals obtain minimum essential coverage?

The ACA addressed several shortcomings that existed in the health insurance market prior to 2010 that prevented individuals from obtaining health insurance coverage. First, the ACA prohibited insurers from discriminating against any individual based on a health factor. As a result, after January 1, 2014, insurers can no longer deny health insurance coverage based on a pre-existing condition. Rather, all persons who apply and pay the applicable premium will be able to procure health insurance for themselves and for their dependents without the imposition of a pre-existing condition exclusion.

The ACA also addressed problems with finding comprehensive affordable coverage by requiring each state to establish a Marketplace for purchasing insurance coverage. Individuals will be able to shop for insurance through the Marketplace, and depending upon eligibility, may be able to receive premium tax credits or subsidies to assist in paying for the coverage. Under the law, individuals with a household income between 100 percent and 400 percent of the federal poverty level are eligible for tax credits for Marketplace coverage if they do not have access to affordable employer-sponsored coverage that is of at least a minimum value.

Lastly, the ACA established the Employer Shared Responsibility, often referred to as the Employer Play or Pay Mandate. This mandate makes employers responsible for either providing coverage to employees or paying a penalty to the federal government for the employer's failure to provide coverage. As noted above, employers that provide coverage must offer affordable coverage that is of at least a minimum value.

Health Reimbursement Arrangement (HRA)

What is a Health Reimbursement Arrangement?

A Health Reimbursement Arrangement (HRA) is an employer-funded arrangement that reimburses employees for certain medical expenses incurred by the employee, their spouses, and their dependents. An HRA is funded solely by the employer and any amounts remaining in an employee's HRA account that are not used to reimburse the employee during the coverage period may be carried over into subsequent coverage periods.

Does KEHP have an HRA available to members?

Yes. For plan year 2013, KEHP offered a health plan that included an HRA. In addition, members were permitted to waive coverage under a health plan option and establish an HRA account. Members who waived coverage could establish a health Waiver HRA or a Waiver Dental/Vision Only HRA. The health Waiver HRA is sometimes referred to in this FAQ as a "stand-alone" HRA.

Do the waiver HRA options comply with federal health care reform requirements?

In 2010, federal regulations stated that health flexible spending arrangements (FSA) – a category that includes most stand-alone HRAs – are exempt from the prohibition on annual limits. As a result, this guidance indicated that a stand-alone HRA was permissible under health care reform. Recent federal guidance, however, suggests that stand-alone HRAs covering active employees might not comply with the ACA as the stand-alone HRAs would violate the prohibition against imposing annual limits on essential health benefits. It should be noted that the issues associated with stand-alone HRAs would not prevent KEHP from offering a health plan with an imbedded HRA as KEHP would ensure that the health plan would not violate the prohibition against annual limits. See the Consumer Protection FAQ section for more information regarding annual limits.

Another fact that complicates the HRA issue is that Kentucky has a state statute requiring the Commonwealth to offer a stand-alone HRA to public employees and to provide monthly credits to the HRA.

Given the conflicting federal guidance regarding HRAs and the state statutory requirements, KEHP is taking steps to seek clarification from the three federal agencies charged with addressing the HRA issue: HHS, Treasury, and DOL.

Will the waiver HRA options be available to KEHP members in 2014?

As noted above, the Commonwealth of Kentucky is seeking further guidance from the federal government regarding HRAs. In seeking such guidance, the Commonwealth contends that stand-alone HRAs are, and should be, exempt from the provision prohibiting group health plans from imposing an annual limit on essential health benefits. The Commonwealth urges the federal Departments to issue guidance as soon as possible clarifying that HRAs do not violate the prohibition on annual limits. In lieu of this clarification, the Commonwealth is urging the federal Departments to extend the current exemption for stand-alone HRAs at least through the end of the 2014 plan year.

While KEHP hopes to be able to continue to offer the health Waiver HRA, the future of these HRAs is unclear. If it is determined that KEHP will be unable to continue to offer the health Waiver HRA in 2014, KEHP will make every effort to establish options for members who wish to waive coverage that (1) meet the members' needs and (2) comply with the mandates of the ACA.